Oregon's Medicaid EHR Incentive Program
(aka Promoting Interoperability Program)
2021 REQUIRED DOCUMENTATION

This checklist details what documentation **must be provided** in support of your attestation. Your attestation cannot be fully processed for payment until the documentation is received[1]. For security purposes, and to promote efficient processing, please upload documentation directly into MAPIR.

Required Documentation Checklist (Pre-Payment)	
☐	**Certified EHR Technology (CEHRT) Documentation** – Supports the adoption, implementation, or upgrade to a 2015 Edition CEHRT. Your 2015 CEHRT must be in place by the beginning of your 90-day EHR reporting period. Acceptable sources include software licensing agreements, signed contract, or vendor letter (as long as it verifies the upgrade to a 2015 certified system). **Note**: If you participated in Program Year 2019 or 2020, you can upload this same CEHRT documentation for Program Year 2021.
☐	**EHR Scorecard/Reports** – Demonstrates requirements for Meaningful Use/Promoting Interoperability Objectives and Electronic Clinical Quality Measures (eCQMs) were met during the reporting period selected (any continuous 90-days in 2021). The EHR report(s) must match your MAPIR attestation, and must be the unaltered, original report from your CEHRT. This document should include the attesting provider's name or NPI, EHR reporting period, EHR name, MU objectives, and eCQMs.
☐	**Application Programming Interface (API) Documentation** – Demonstrates the provider has ensured patients' information is available to access using any application of their choice that is configured to meet the technical specification of the API in the providers' CEHRT (requirement for Objective 5 Measure 1). This document must contain the API-enabled date, or a date prior to EHR reporting period, and may come in different formats: • EHR screenshot(s) with enabled date and provider/location name • Vendor letter confirming API was enabled prior to calendar year 2021 EHR reporting period • Copy of instructions provided to patients on how to authenticate their access through an API • Copy of instructions given to patients on available application that leverage the API **Note**: If you participated in Program Year 2019 or 2020, you can upload this same API documentation for Program Year 2021.

[1] There is an exception to this rule for providers who conduct/review their annual security risk analysis (SRA) late in the calendar year. If these providers do not yet have their 2021 SRA documentation to provide when they submit their attestation (by 8/31/21), they may submit it after the August deadline. For providers who normally conduct their SRA during the month of December, they have until 1/31/22 to submit their SRA to staff. Providers in this situation will receive their payment before staff can review their SRA, which puts providers at risk for post-payment audit and incentive payment recoupment if their 2021 SRA is not received by the January deadline.

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☐ **Security Risk Analysis (SRA)** – Demonstrates risks to electronic protected health information (ePHI) have been assessed. A unique SRA must be reviewed or conducted for each calendar year. Documentation must include:

- Date SRA was completed (must be in calendar year 2021)
- Organization SRA was completed for and name of who completed SRA
- Identified risks, threats, or vulnerabilities to ePHI

Note: One SRA can be provided for group submissions.

☐ **Public Health and Clinical Data Registry Reporting** (Objective 8) – Required documentation for these measures includes <u>two</u> components:

1. A letter from the registry that identifies
    a. The name of the attesting EP/clinic
    b. The attesting EP's/clinic's status of active engagement (1 - completed registration, 2 – testing and validation, 3 – production)
        - If in option 1, the letter must identify the date of the registration. This date must be before, or within 60 days of the start of the attesting provider's EHR reporting period.
        - If in option 2, the letter must identify whether any requests were made, and that the clinic has responded to requests in a timely fashion (within 30 days).
        - If in option 3, the letter must contain a statement that the EP/clinic is actively submitting production data.

    Notes:
    - A registry screenshot is acceptable in lieu of a letter from registry, if it can substantiate the details of the letter. This is the expected documentation for EPs attesting to Oregon's Prescription Drug Monitoring Program (PDMP) for **Measure 4**. EPs would obtain this themselves, not contact PDMP staff for the document.
    - If the EP was already in option 3 (production) prior to 2021, there is no need to obtain a new letter for the public health registry; simply upload the public health letter from a prior year verifying this.
    - For **Measure 4**, an EP may count a specialized registry (such as PDMP) if the EP achieved Active Engagement Option 3 (production) in a prior year.
    - For **Measure 1**, Immunization Registry Reporting, you do not need to upload any documentation. The MEHRIP staff will obtain this for you.
    - **Measure 2**, Syndromic Surveillance Reporting, is only available to urgent care providers.

2. List of providers and NPIs (preferably in Excel format) created by the clinic that identifies all the individual providers submitting to that registry.

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Other documentation may be required on a case-by-case basis. The below documents may not be required for everyone, but may be requested as we process your attestation.

☐	**Practice Predominantly Form** – Verifies over 50% of patient encounters have occurred in an FQHC/RHC in a designated 6-month period. **This is only for providers who primarily work in a Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC).** The form is on our Manuals and Other Resources webpage.
☐	**Patient Volume Report** – Documentation that supports your 90-day patient volume period (in an Excel spreadsheet format). During our pre-payment review, we may find that 1) the patient volume is at risk of not meeting the 30% (or 20% for pediatricians) Medicaid patient volume threshold, or 2) we cannot validate your attested patient volume amounts. A patient volume report displays ONLY Medicaid and needy (if FQHC/RHC) encounters during the 90-day patient volume timeframe used for the provider's numerator, and must include the following data fields: - Date of Service - Medicaid Patient ID - Amount Billed (if available in current report) - Rendering Provider NPI (if doing group patient volume)

A note about post-payment audits:

The above documentation pertains to what program staff request before an incentive payment can be issued. However, in the event a provider is selected for a post-payment audit, additional supporting documentation will be requested. In addition to all of the pre-payment documentation described above, the auditor may request more documentation regarding the SRA, patient volume, and API functionality and potentially other areas, on a case-by-case basis. Because of this, please retain all documentation supporting incentive payment eligibility for a minimum of six years.